Prescription Drugs	Mail Service Pharmacy	Participating Pharmacy	All Other Pharmacies
*Contraceptives: Generic oral contraceptives, generic injections, Mirena IUD, Nexplanon implant, Ortho Evra patch, Nuvaring, Ortho Flex, Ortho Coil, Ortho Flat, Wide-seal, Omniflex, Prentif and Femcap-vaginal	Prescription Drugs will be covered at 100%, up to a 90-day supply	Prescription Drugs will be covered at 100%, up to a 31 day-supply	The Member will be responsible for 100% of the Allowable Charge at the pharmacy, then will be reimbursed at 100%, up to a 31-day supply
**All Other Contraceptives (Prescription Drugs)	Covered	Covered	Non-Covered

***Contraceptives listed above are covered under the participating medical benefits at the same payment levels. Refill quantities for the contraceptives listed above may vary.**
****All other contraceptives are paid at the Generic, Preferred Brand and Non-Preferred Brand Drug payment levels.**

SPECIALTY DRUG BENEFIT		
	Participating Pharmacy	**All Other Pharmacies**
Specialty Drugs	$100 Copayment per Member for each prescription or refill, up to a 31-day supply	Non-Covered

VISION SCHEDULE OF BENEFITS (Healthy Vision)		
Vision Care Services	**Participating Providers**	**Non-Participating Providers Allowance**
Exam with Dilation as Necessary	$15 Copayment	$35
Contact Lens Fit and Follow-Up: Standard Contact Lens Fit and Two Follow-up Visits*	$0 Copayment	$40
Premium Contact Lens Fit and Two Follow-up Visits **	10% off retail price, then apply $55 allowance	$40
Frames (Any available frame at provider location)	$110 allowance, 20% off balance over $110	$55
Standard Plastic Lenses: Single Vision	$0 Copayment	$25
Bifocal	$0 Copayment	$40
Trifocal	$0 Copayment	$55
Lens Options: UV Coating	$15	Non-Covered
Tint (Solid and Gradient)	$15	Non-Covered
Standard Scratch-Resistance	$15	Non-Covered
Standard Polycarbonate	$40	Non-Covered
Standard Anti-Reflective Coating	$45	Non-Covered
Standard Progressive (Add-on to Bifocal)	$65	Non-Covered
Other Add-Ons and Services	20% off retail price	Non-Covered

* **Standard Contact Lens Fitting - spherical clear contact lenses in conventional wear and planned replacement (Examples include but not limited to disposable, frequent replacement, etc.)**

** **Premium Contact Lens Fitting - all lens designs, materials and specialty fittings other than Standard Contact Lenses (Examples include toric, multifocal, etc.)**

Vision Care Services	Participating Providers	Non-Participating Providers Allowance
Contact Lenses:		
Conventional	$0 Copayment, $110 allowance, 15% off balance over $110	$88
Disposable	$0 Copayment, $110 allowance, plus balance over $110	$88
Medically Necessary	$0 Copayment, Paid-in-Full	$200
Frequency:		
Examination	Once every 12 months	
Frame	Once every 24 months	
Lenses or Contact Lenses	Once every 24 months	

Additional Discounts:

- Member will receive a 20% discount on items not covered by the plan at Participating Providers, which may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed Provider's professional services, or contact lenses. Retail prices may vary by location.
- Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time use benefits; no remaining balance.
- Lost or broken materials are not covered.
- Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.
- Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA vision. Since Lasik or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization please call 1-877-5LASER6.
- After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. The contact lens benefit allowance is not applicable to this service.

Plan Limitations/ Exclusions:

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing,
- Plano non-prescription lenses and non-prescription sunglasses (except for 20% discount),
- Medical and/or surgical treatment of the eye, eyes, or supporting structures,
- Services or materials provided by any other group benefit providing for vision care,
- Services provided as a result of any Workers' Compensation law,
- Two pairs of glasses in lieu of bifocals,
- Aniseikonic lenses,
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under the plan,
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.

PREFERRED BLUE®
PLAN OF BENEFITS

South Carolina

BlueCross BlueShield of South Carolina
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ARTICLE I - DEFINITIONS

Capitalized terms that are used in this Plan of Benefits shall have the following defined meanings:

Actively at Work: a permanent, full-time employee who works at least the minimum number of hours per week and the minimum number of weeks per year (each as set forth on the Schedule of Benefits) and who is not absent from work during the initial enrollment period because of a leave of absence or temporary lay-off. An absence during the initial enrollment period due to a Health Status-Related Factor will not keep an employee from qualifying for Actively at Work status.

Admission: the period of time between a Member's admission as a patient into a Hospital or Skilled Nursing Facility and the time the Member leaves or is discharged.

Adverse Benefit Determination: any denial, reduction or termination of, or failure to provide or make (in whole or in part) payment for a claim for Benefits, including any such denial reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or Member's eligibility to participate in a plan, and including, a denial reduction or termination of, or failure to provide or make payment (in whole or in part) for a Benefit which results from the application of any utilization review as well as a failure to cover an item or services for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Allowable Charge: the charge payable by the Corporation. The payment will not exceed the Maximum Payment.

Alternate Recipient: any Child who is recognized under a Medical Child Support Order as having a right to enroll in this Plan of Benefits.

Ambulatory Surgical Center: a licensed facility that:

1. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;

2. Provides treatment by or under the supervision of medical doctors or oral surgeons and provides nursing services when the Member is in the facility;

3. Does not provide inpatient accommodations; and,

4. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a medical doctor or oral surgeon.

Ambulatory Surgical Center includes an endoscopy center.

Benefit Year: the period of time set forth on the Schedule of Benefits. The initial Benefit Year may be more or less than twelve (12) months.

Benefit Year Deductible: the amount, if any, listed on the Schedule of Benefits that must be paid by the Member each Benefit Year before the Corporation will pay Covered Expenses. The Benefit Year Deductible is subtracted from the Allowable Charge before Coinsurance is calculated. Members must refer to the Schedule of Benefits to determine if the Benefit Year Deductible applies to the Out-of-Pocket Maximum.